

Community Benefit Reporting Form Instructions

State of Oregon

Attention: The community benefit reporting form instructions have been updated to reflect changes in the community benefit program prescribed by HB 3076 (2019). The new community benefit reporting form and new data reporting requirements are required beginning in fiscal years 2022.

Background

In 2007, HB 3290 established Oregon's community benefit reporting law in order to document the benefits that hospitals provide to their communities. In 2019, HB 3076 expanded the reporting requirements and introduced the minimum community benefit spending floor program. Oregon Revised Statute 442.601 defines community benefit as a "program or activity that provides treatment or promotes health and healing, addresses health disparities or addresses the social determinants of health in response to an identified community need." The Oregon Health Authority (OHA) is required to adopt a cost-based community benefit reporting program that is consistent with established national standards for hospital reporting of community benefits.

Hospital community benefit costs are reported to OHA on the Community Benefit Reporting (CBR-1) form. The community benefit program and reporting forms are modelled around standards developed by the Catholic Health Association (CHA)¹ and adapted to meet the unique policy needs in Oregon. The following instructions are intended to provide guidance on how to fill out Oregon's CBR-1 form in order to assure accurate and consistent community benefit reporting across hospitals.

Oregon's community benefit policies are similar to those specified on the IRS 990 schedule H form with a few notable exceptions. Places where Oregon differs from IRS guidelines are noted in these instructions.

Filing Instructions

Each hospital has 240 days following the close of its fiscal year to file a CBR-1 form with OHA's Office of Health Analytics. Health systems operating more than one hospital should file a separate CBR form for each Oregon hospital.

Copies of the CBR form may be obtained on OHA's hospital reporting website:

http://www.oregon.gov/oha/OHPR/RSCH/pages/hospital_reporting.aspx

The CBR-1 form is a guided Microsoft Excel workbook that leads a hospital through the required reporting categories. Completed submissions should be emailed to hdd.admin@state.or.us

¹ For additional information on the Catholic Health Association and its community benefit reporting program, see www.chausa.org/communitybenefit.

If a hospital cannot complete a CBR within 240 days of the end of its fiscal year, it may request an extension by emailing hdd.admin@dhsosha.state.or.us. Extension requests should be submitted 30 days prior to the hospital's reporting deadline and include facts or reasons in support of the request and describe a clear timeline for remediating delays and submitting the CBR form. OHA management will review all requests for approval. Failure to submit the required community benefit information could result in a civil penalty up to \$500 per day (Oregon Administrative Rules 409-023-0105).

General Tips

Community benefit reporting on the form CBR-1 is reporting costs associated with community benefit activities. While this instruction manual will provide guidance and examples, it is impossible to identify every possible qualifying community benefit activity a hospital may engage in. To determine whether an activity can be considered community benefit, there are some key high-level rules of thumb:

1. Community benefit isn't for advertising, marketing, or increasing business.

This means the primary benefactor of the activity is a patient, community member, organization, or the community at large. While this doesn't exclude the possibility that there are some mutually beneficial aspects to the hospital, it generally means activities cannot be used for the primary purpose of marketing, to increase referrals, or to generate profit to the hospital.

2. Community benefit is a cost.

The CBR-1 form is a cost-based reporting program. Activities that generate a profit are not considered community benefit for the purposes of this reporting.

3. Community benefit is purposeful and responds to identified community need.

As is noted in statute, community benefit is in response to an identified community need. Community benefit activities the hospital undertakes should relate to areas of need it has identified through its community needs assessment. Hospitals should be able to make a clear connection between the activity and the hospitals' goals and strategies to address community need.

Step by Step Instructions

The following provides detailed instructions for hospitals filling out Oregon's CBR-1. For clarity, shaded boxes throughout these directions describe where Oregon's community benefit reporting is different from the IRS' Schedule H.

Reporting hospitals should include all activities within Oregon that are under the governance of the hospital whether physically in the same location as the hospital or not. If the hospital is part of a system that has governance responsibility over the hospital, then the costs of the community benefit activities provided by the system in Oregon should be allocated to the

system's individual hospitals based on an allocation methodology attempting to match where the community benefit is provided.

Upon submittal, OHA staff review each CBR form to check for consistency with each hospital's audited financial statement and CBR forms from previous years. As a result, OHA staff may contact hospitals with questions regarding the CBR form prior to publishing the data on the state's website. Accordingly, hospitals reporting large changes in community benefit from one year to the next should include additional information in their filing for clarity.

HOSPITAL INFORMATION (workbook tab "Step 2. Hospital Information")

Hospital Name

The reporting entity should be the individual hospital located within Oregon. Health systems with multiple hospitals must submit a CBR-1 form for each individual hospital operating in Oregon. Please report the hospital name as the organization would like it to appear in OHA's published reports of community benefit data.

Comparison with Schedule H: Unlike Oregon's CBR form, hospital systems may not be required to submit a separate Schedule H for each hospital. Hospital systems that operate multiple hospitals under a single Employee Identification Number submit a consolidated Schedule H (with the exception of Part V). Additionally, for-profit hospitals and tax-exempt District hospitals are not required to submit a Form 990, Schedule H. Oregon requires all hospitals to submit the CBR form.

Hospital System

If the hospital is part of a larger hospital system or healthcare organization, include the system's name here. If not, please write "none."

Reporting Period

The reporting period should correspond to the hospital's fiscal year. For example, "July 1, 2021 - June 30, 2022."

Contact Information

Please include the contact information for the person OHA should contact if we have questions about the information submitted.

Additional clinics included on the CBR-1 form

Please identify any outpatient clinics or other health care facilities associated with the hospital whose community benefit activities are represented on the CBR-1 form. These include any hospital-affiliated clinic as defined by ORS 442.612 In considering whether units within a hospital should be identified as a clinic, consider how the hospital advertises or markets the unit. If the public would readily identify the unit as a sub-part to the hospital, it should be identified individually in this section.

Community Health Improvement Services, Community Building Activities, Community Benefit Operations (Workbook tab “Step 3. CHI, CBA, CBO)

Community Health Improvement Services

These are activities that are carried out to improve community health based on an identified community need. These services do not generate inpatient or outpatient bills. They may involve a nominal patient fee or sliding scale fee.

Steps for reporting community health improvement services:

1. Write the name or description of the community health improvement service provided.
2. Input total qualifying expenses for each individual community health improvement service offered.
3. Input any direct offsetting revenue received.
4. Cite the number of encounters for each community health improvement service. This may include counting an individual more than once if they accessed the service more than once. Reasonable estimations may be used here.

Community Health Improvement Services guidelines and examples

Health Care Support Services

Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other underserved populations.

Count:

- Information and referral to community services for community members (not routine discharge planning).
- Case management of underinsured and uninsured persons open to the community that goes beyond routine discharge planning.
- Telephone information services, such as medical and mental health service hotlines and poison control centers.
- Transportation programs for patients and families to enhance patient access to care. Assistance for enrollment in public programs, such as CHIP and Medicaid.
- Personal response systems, such as Lifeline.

Do not count:

- A physician referral, if it is primarily an internal marketing effort. However, you may count a physician referral from a call center if the call center makes referrals to other community organizations or physicians from across an area, without regard to admitting practices.

- Health care support given to patients and families in the course of an inpatient or outpatient encounter.
- Routine discharge planning.
- Enrollment assistance programs designed to increase facility revenue.

Support Groups

Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences: diseases and disabilities, grief, infertility, support for patients' families, or others. These groups may meet on a regular or an intermittent basis.

Count:

- Costs to run support groups related to community need.

Do not count:

- Support given to patients and families in the course of their inpatient or outpatient encounter.
- Classes that are reimbursed or designed to attract paying or insured patients.

Self-Help Programs

These include wellness and health-promotion programs, such as those for smoking cessation, exercise, and weight loss.

Count:

- Health promotion and wellness programs such as anger management, exercise classes, smoking cessation programs, stress management classes, weight loss and nutrition programs.

Do not count:

- Employee wellness and health promotion provided by your organization as an employee benefit.
- The use of facility space to hold meetings for community groups (Report in Cash and In-kind Contributions).

Community Health Education

This includes lectures, presentations, and other group programs and activities apart from clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs.

Count:

- Caregiver training for persons caring for family members at home.
- Community calendars and newsletters primarily intended to educate the community about community health programs and free community events.

- Consumer health libraries.
- Education on specific diseases or conditions, such as diabetes or heart disease.
- Health fairs, health promotion and wellness programs, and health education lectures and workshops in response to community need (not primarily for marketing).
- Parish and congregational programs.
- News releases and other modes to the media (radio, television, and print) to educate the public about health issues (such as wearing bike helmets, new treatment news, health resources in the community, etc.).
- School health-education programs (report school-based programs on health care careers and workforce enhancement efforts in row 12, Community Building Activities. Report school-based health services for students in this category).
- Web-based consumer health information. Worksite health education programs.

Do not count:

- Health education classes designed to increase market share (such as prenatal and childbirth programs for insured patients)
- Community calendars and newsletters, if they are primarily used as marketing tools
- Patient education services understood as necessary for comprehensive patient care (e.g., diabetes education for patients).
- Health education sessions offered for a fee, for which a profit is realized. Volunteer time for parish and congregation-based services.

Community-Based Clinical Services

These are health services and screenings provided on a one-time basis or as a special event in the community. These programs could include free clinics for medically underinsured and uninsured individuals. As with other categories of community benefit, these services and programs should be counted only if they are designed to meet identified community needs or to improve community health. To be considered community benefit, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured.

Count:

- The hospital's costs (such as grants, staff time, equipment, overhead, labs and medication) of providing one-time or occasionally held clinics including blood pressure or cholesterol screening clinics, cardiology risk factor screening clinics, colon cancer screening clinics, dental care clinics, immunization clinics, primary care clinics, school physical clinics, stroke screening clinics, and mobile units that deliver primary care to underserved populations on an occasional or one-time basis.
- Staff volunteer time if clinic occurs during normal working hours.
- Include offsetting revenue from other community partners that assist in funding the activity.

Do not count:

- Clinics for which a profit is earned.
- Permanent, ongoing programs and outpatient services. These should be counted as Subsidized Health Services.
- Screenings where referrals are made only to the health care organization or its physicians.
- Screenings provided primarily for public relations or marketing purposes.
- Volunteers' time or staff time outside normal working hours.

Community Building Activities

These are programs that affect the social determinants of health and health equity. Activities are not direct health care services but rather provide opportunities to address the root causes of health problems, such as poverty, homelessness, racism, and environmental issues. These activities support community assets by offering the expertise and resources of the health care organization. Costs for these activities include cash, in-kind donations, and budgeted expenditures for the development of a variety of community health programs and partnerships.

Activities include physical improvements and housing, economic development, community support, environmental improvements, leadership training for community members, coalition building, community health Improvement advocacy, and workforce development.

Remember to subtract any subsidies or grant amounts from total expenses incurred in this category. Also remember to not double count grants or cash contributions to businesses or community members in this category that would also be counted in the cash and in-kind contribution category, or vice versa.

Steps for reporting community building activities:

1. Write the name or description of the community building activity.
2. Input total qualifying expenses for each individual community building activity
3. Input any direct offsetting revenue received.

Community building activities guidelines and examples**Count:**

- Neighborhood improvements such as lighting, tree planting, graffiti removal, housing rehabilitation or other revitalizations.
- Walkability improvements such as sidewalk construction or walking path construction.
- Park or natural area building.
- Low income housing support.
- Economic development such as job or skill training (not related to health professions education), life skill training, or interviewing practice.
- Grants or support of community-based programs such as libraries, museums, senior centers, or civic centers.

- Childcare services.
- Environmental improvements or clean-up.

Do not count:

- Employee housing costs.
- Hospital facility or medical facility construction.
- Business investments or joint ventures than supply revenue to the facility.
- Landscaping of hospital grounds or maintenance.
- Environmental improvements of hospital facilities that are required by law.

Community Benefit Operations

This category includes the costs associated with staffing and coordinating the hospital's community benefit initiatives.

Comparison with Schedule H: On the Schedule H, Community Health Improvement Services (row 7 on the CBR) and Community Benefit Operations (row 13 on the CBR) are combined as a single category.

Steps for reporting community benefit operations costs:

1. Write the name or description of the community benefit operation expense item (ex. Community benefit coordinator salary and benefits).
2. Input total qualifying expenses for each community benefit operation expense.
3. Input any direct offsetting revenue received.

Community benefit operations guidelines and examples

Count:

- Staff costs for managing or overseeing community benefit program activities that are not included in other categories of community services.
- Staff costs to coordinate community benefit volunteer programs.
- Staff costs for internal tracking and reporting of community benefit.
- Costs associated with developing community health needs assessments, strategic implementation plans or community health improvement plans.
- Fundraising or grant writing costs related to community benefit services and activities.

Do not count:

- Staff time to coordinate in-house volunteer programs.
- Market share analysis or marketing surveys.
- Grant writing or other fundraising costs for hospital programs that are not related to community benefit.

Health Profession Education (Workbook tab “Step 4. Health Profession Ed”)

This category includes educational programs that are available to physicians, medical students, interns, residents, nurses and nursing students, and other health professionals that are not available exclusively to the hospital’s employees. Helping to prepare future health care professionals is a distinguishing characteristic of not-for-profit health care and constitutes a significant community benefit.

Costs are the direct costs of providing such programs. For the costs associated with proctoring students, time studies should be performed measuring the incremental time the hospital employees spend with the students, not the total time students spend within the facility. Include cost of medical libraries open to the general public.

Expenses are to be offset by Medicare and Medicaid reimbursement for direct graduate medical education (GME), continuing health professionals’ education reimbursements, and tuition from students. Do not count cost for in-services training, orientation programs, or other training programs for hospital employees.

Steps for reporting Health Profession Education Costs:

1. Input total number of professionals supported in the listed categories.
2. Input total expenses for each listed health professional category.
3. Provide total offsetting revenue, including Medicare and Medicaid Direct GME payments and any collected tuition or fees associated with the program. Hospitals do not need to count indirect GME payments as offsetting revenue.

Health Profession Education guidelines and examples

Physicians/medical students/residents/interns

Count:

- The unpaid costs of a clinical setting for undergraduate training, internships, clerkships, and residencies.
- Continuing medical education (CME) offered to physicians outside of the medical staff on subjects for which the organization has special expertise.
- The offsetting revenue from government subsidies and tuition.

Do not count:

- Expenses for physician and medical student in-service training and orientation programs.
- Joint appointments with educational institutions and medical schools.
- Costs of CME restricted to members of the medical staff.

Nurses/nursing students

Count:

- Providing a clinical setting for undergraduate/vocational training to students enrolled in an outside organization.
- Internships or externships when on-site training of nurses (e.g., LVN or LPN) is subsidized by the health care organization.
- Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty.

Do not count:

- Education required for nursing staff, such as orientation, in-service programs, and new graduate training.
- Expenses for standard in-service training and in-house mentoring programs.
- In-house nursing and nursing assistant training programs.

Other Health Professional Education

Count:

- A clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, pharmacists, and other health professionals.
- Training of health professionals in special settings, such as occupational health or outpatient facilities.
- Unpaid costs of medical translator training beyond what is mandated.
- Program costs associated with high-school student job shadowing and mentoring projects.

Do not count:

- Education required by staff, such as orientation and standard in-service programs.
- On-the-job training, such as pharmacy technician and nursing assistant programs.
- Staff time delivering care concurrent with job shadowing.

Scholarships/Funding for Health Professions Education

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement.
- Scholarships or tuition payments for professional education or training to non-employees, volunteers, or community members.
- Specialty in-service and videoconferencing programs made available to professionals in the community.

Do not count:

- Costs for staff conferences and travel other than those listed above.
- Financial assistance for employees who are advancing their own educational credentials.

- Staff tuition reimbursement costs provided as an employee benefit.

Research and Cash and In-Kind Contributions (Workbook tab “Step 5. Research & Cash inkind”)

Research

Include research costs for research that is made publicly available and is consistent with community need. Research includes clinical and community health research, as well as studies on health care delivery that are shared with others outside the organization. Do not count research where findings are used only internally. Priority should be placed on issues related to reducing health disparities and preventable illness.

Grant funding (ex. National Institutes of Health research grants, Centers for Disease Control and Prevention grants) should be accounted for as offsetting revenue.

Count:

- Research development costs.
- Clinical trials where findings are published.
- Studies on therapeutic protocols.
- Evaluation of innovative treatments.
- Research papers prepared by staff for professional journals.
- Studies on health issues for vulnerable persons.
- Studies on community health, such as incidence rates of conditions for populations.
- Studies on innovative health care delivery models.
- Offsetting grant revenue.

Do not count:

- Research where findings are only used internally or for proprietary purposes.

Cash and In-Kind Contributions

This category includes funds and in-kind services donated to individuals or the community. In-kind services include hours donated by staff to the community while on work time, overhead expenses of space donated to not-for-profit community groups (such as for meetings), and donation of food, equipment, and supplies. As a general rule, count donations to organizations and programs that are consistent with your organization’s goals and mission.

Cash Donations

Count:

- Contributions and matching funds provided to not-for-profit community organizations.
- Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization.
- Contributions provided to individuals for emergency assistance.

Do not count:

- Employee-donated funds.
- Emergency funds provided to employees.
- Fees for sporting event tickets.
- Time spent at golf outings or other primarily recreational events.

Grants

These include contributions and matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives.

Count:

- Program, operating, and education grants.
- Matching grants.

Do not count:

- Grants passed through from a related organization.

*In-Kind Donations***Count:**

- Meeting room overhead and space for not-for-profit organizations and community groups (such as coalitions, neighborhood associations, and social service networks).
- Equipment and medical supplies.
- Emergency medical care at a community event.
- Costs of coordinating community events not sponsored by the health care organization. Employee costs associated with board and community involvement on work time.
- Food donations, including Meals on Wheels subsidies and donations to food shelters.
- Laundry services for community organizations.
- Technical assistance to community organizations, such as information technology, accounting, human resource support, process support, planning, and marketing.

Do not count:

- Employee costs associated with board and community involvement when these are done on an employee's own time.
- Volunteer hours provided by hospital employees on their own time for community events.

Cost to Charge Ratio (Workbook tab "Step 6. CCR")

Complete the Cost to Charge Ratio worksheet. The excel workbook will carry forward the cost to charge ratio information to the remaining community benefit categories. Complete the worksheet even if the hospital intends to provide expenses using cost accounting methods.

[Steps for completing cost to charge ratio worksheet](#)

1. Input total operating expense for the entire fiscal year which is being reported. This operating expense amount should match what is reported to OHA on form FR-3 for audited financial reporting purposes.
2. Input bad debt expense only if bad debt is counted as an expense in the total operating expense amount provided above.
3. Input expenses incurred for non-patient care activities. Non-patient care activities are defined and interpreted in the same manner as the federal form 990 and primarily include expenses related to hospital operations that generate other operating revenue for the hospital.
4. Input total Medicaid provider taxes, fees or assessments paid in the fiscal year.
5. Community benefit expenses from services not related to patient care will auto populate based on previously reported data.
6. Input total gross patient charges for the entire fiscal year which is being reported. This gross patient charges amount should match what is reported to OHA on form FR-3 for audited financial reporting purposes.
7. Report any gross charges for community benefit programs, if any.
8. Remaining fields will auto-calculate.

Charity Care at Cost (Workbook tab “Step 7. Charity Care”)

Charity care means free or discounted health services provided to persons who meet the eligibility criteria of the organization’s financial assistance policy. Charity care is differentiated from bad debt based on expectation of payment. Charity care is reported in terms of costs, not charges.

When possible, report the number of patients, total charges, offsetting revenue and number of patients provided 100 percent charity care by payer (Medicaid, Medicare, Commercial insurance, uninsured and other). If hospital accounting systems prevent the reporting of charity care by payer, input total amounts in the Other Payer lines (Line 5a-5d).

Steps for completing the charity care at cost worksheet

1. Input total number of patients provided charity care, by payer if possible. Include all patients that received any level of charity care discount, even if only partial fee reduction.
2. Input total gross charges, by payer if possible. Do not discount for contractual or other adjustments. NOTE: If hospital is using a cost accounting method, input net cost directly in the space provided on the workbook. Do not provide gross charges and revenue.
3. Input total revenue received, by payer if possible. Include all reimbursement amounts, including pass through payments, add-on payments or incentive payments.
4. Input any revenue received from uncompensated care pools or programs, if any.
5. The workbook will auto calculate total figures.

Count:

- The costs of providing free and discounted care to those who meet the eligibility criteria for the hospital’s financial assistance policy.
- Expenses incurred by the provision of financial assistance.

Do Not Count:

- Bad debt, contractual allowances, quick-pay discounts, or discounts provided to all self-pay patients (i.e. those who do not qualify for the hospital’s financial assistance policy).
- Payments to and reimbursement from Oregon’s hospital provider tax program. These should be included in Medicaid.

Unreimbursed Costs of Public Programs and Subsidized Health Services (Workbook tab “Step.8 Unreimbursed programs”)

Medicaid/Managed Medicaid/ Children’s Health Insurance Programs (CHIP)

Unreimbursed costs for Medicaid are the shortfall created when a facility receives payments that are less than the cost of caring for Medicaid or CHIP beneficiaries.

The Medicaid worksheet on the step 8 tab of the CBR-1 form will walk hospitals through calculating the unreimbursed costs of Medicaid. Direct offsetting revenue should include any revenues related to Medicaid, including patient payments, cost report settlements, lump sum adjustments, capitated payments, and Medicaid disproportionate share hospital (DSH) revenue. Also include any provider tax reimbursement amounts, such as qualified directed payments or hospital reimbursement adjustment amounts.

Other Public Payer Programs

Report the unpaid costs of other non-Medicare, non-Medicaid public programs. Similar to unreimbursed costs of Medicaid, this is the shortfall created when a facility receives payments that are less than the cost of caring for other public medical programs including Tricare, Champus, Veterans Health Administration, Indian Health Service, and other federal, state, or local programs.

Comparison with Schedule H: Schedule H only allows hospitals to include the unpaid costs of “means-tested government programs”—a health program for which eligibility depends on the recipient’s income or asset level. As a result, several government programs eligible for inclusion on Oregon’s CBR, like Veterans Health Administration and Indian Health Service, are not reported on the Schedule H because they are not means-tested programs.

Subsidized Health Services

Subsidized health services are clinical service lines that are provided despite a financial loss because they meet an identified community need and it is reasonable to conclude that if the hospital no longer offers the service, then the service would be unavailable in the community, the community’s capacity to provide the service would be below the community’s need, or the service would become the responsibility of government or another tax-exempt organization.

It is important to remove costs and offsetting revenues already counted in quantifying the unpaid cost of charity care, Medicaid, and other public programs so as not to double count these community benefits. In other words, to be included the service should have a financial loss after removing losses associated with bad debt, charity care, Medicaid, and other public programs.

Count:

- Clinical programs or service lines meeting a community need that the hospital subsidizes.

Do not count:

Any costs previously capture in other community benefit categories such as:

- Charity care.
- Medicaid shortfalls.
- Other public payer programs.

Do not count losses related to:

- Bad debt.

Several services frequently qualify for Subsidized Health Services to the extent they are subsidized:

Emergency and Trauma Services

Count:

- Air ambulance.
- Emergency department.
- Local community emergency medical technician (EMS) training.
- Trauma center.

Do not count:

- Payment for routine on-call physician services.

Neonatal Intensive Care

Hospital Outpatient Services

Count:

- Subsidized permanent outpatient services and primary/ambulatory care centers, whether they are within the hospital facility or separate, freestanding facilities (e.g., urgent care center).
- Mobile units, including mammography and radiology units.

Burn Units

Women's and Children's Services

Count:

- Freestanding breast diagnostic centers.
- Newborn care.
- Obstetrical services.
- Pediatrics.
- Women's services.

Do not count:

- Services provided in order to attract physicians or health plans.

Renal Dialysis Services

Subsidized Continuing Care

Count:

- Hospice care.
- Home care services.
- Skilled nursing care or nursing home services.
- Senior day health programs.
- Durable medical equipment.

Do not count:

- Step-down or post-acute services provided in order to discharge outlier patients, to the financial advantage of the facility.

Behavioral Health Services

Palliative Care

Count:

- Special programs to address the palliative care needs of patients. These programs usually involve the formation of an expert team and go beyond the routine pain control efforts expected of all health care facilities.

Do not count:

- Routine pain control program.

Supplemental Narrative Questions

In addition to completing the CBR-1 form, hospitals shall prepare a supplemental narrative describing their community benefit program. Hospitals must include the following:

1. The year of publication for the current community health needs assessment.
2. The top health needs identified in the hospital's most recent community health needs assessment. Include information on geographies, populations or demographic groups affected.
3. The significant community benefit activities the hospital engaged in that addressed the health needs identified above.
4. Identify any community benefit activity that addresses the social determinants of health. Separate activities into those that:
 - a. Address individual health-related social needs
 - b. Address systemic issues or root causes of health and health equity

Narratives will be publicly available and used to provide context to the community benefit activities quantified on form CBR-1. Hospitals should take care to provide an accurate and comprehensive account of their community benefit program for the given fiscal year.

The narrative should focus on activities occurring within the fiscal year of the CBR-1 report; however, it is allowable to describe ongoing programs and activities from past years, and programs that will extend into the future.

The year of publication for the current community health needs assessment.

Federal IRS codes require hospitals to conduct a community health needs assessment every three years. Hospitals should indicate the year the current community health needs assessment was first published.

State the top health needs identified in the hospital's most recent community health needs assessment. Include information on geographies, populations or demographic groups affected.

Hospitals should touch on three key aspects when describing the health needs described below. Hospitals can address the items below in any order as a component of the narrative description.

1. Summarize the process used to determine the health need, specifically identifying any collaborations with CCOs, local public health agencies, or community groups and the role played by the hospital in those collaborations.

While summarizing, describe key methods used to identify needs, such as key informant interviews, surveys, health records reviews or any other method used to assess health needs.

List major collaborators in the process and their major contributions. Specifically note and describe collaboration with CCOs and local public health agencies.

2. As applicable, identify the geographic regions experiencing the health needs.

If a health need is unique to a specific region of the hospital's service area, describe the geographic region experiencing the health need and any pertinent information related to that health need. This may include both environmental or social factors unique to the area that impact the health need. Please describe any event during the reporting period that may have affected health in the region, such as a wildfire.

Examples of environmental or social factors related to geographic regions:

- Distance or access to services
- Mountain roads or difficult traveling terrain
- Inclement weather risks
- Economic status indicators such as median incomes, house prices, per capita income, home ownership rate
- Crime rates
- Drug use or other risk behaviors
- Air quality (pollution, wildfire, industry or other)

3. As applicable, identify the populations or demographic groups affected.
Describe the characteristics of the population that inform the health need.

Examples of populations or demographic factors:

- Race or racial groups
- Ethnicity or ethnic groups
- Age or age categories
- Spoken language
- Disability
- Chronic conditions
- Economic status
- Immigration status
- Sexual orientation
- Gender identity

Identify the significant community benefit activities the hospital engaged in that addressed the health needs identified above.

Hospitals should address the items below, in any order, in their narrative response.

1. **Identify spending associated with each community benefit activity.** These amounts do not have to directly correlate to specific categories reported on form CBR-1, although

reporting should follow the same basic standards: report net costs after offsetting revenue and do not double count the same expense in more than one activity. If a cost applies to multiple community benefit activities, reasonably apportion the total cost to each activity.

Hospitals should identify recipients of grants totaling \$5,000 or more dollars. Hospitals may aggregate up grants or awards on a similar topic and report as a single item. For example, a hospital that awards college scholarships may report the total of all scholarships awarded such as the following: Hospital A provided 25 scholarships ranging from \$1,000 to \$5,000 for a total of \$50,000.

2. **Identify the activities' target populations and the health priorities addressed.**
Describe what target population and what health need the community benefit activity addressed. If the health need was not previously described as a key identified health need, briefly indicate the origin of the health need or the reason for the community benefit investment.
3. **When possible, include evaluation or outcome measures and/or results.** Hospitals should report any impact on health needs identified, particularly for ongoing activities over the course of multiple years. Report observed changes in disease rates, changes in health outcomes or any other relevant reportable impact attributed to the community benefit activity.

Identify any community benefit activity that addresses the social determinants of health and/or health equity. Separate activities into those that:

- A) address individual health-related social needs, or**
- B) address systemic issues or root causes of health and health equity.**

Hospitals should identify community benefit activities that address social determinants of health or health equity. Statute defines social determinants of health as “the social, economic and environmental conditions in which people are born, grow, work, live and age, shaped by the distribution of money, power and resources at local, national and global levels, institutional bias, discrimination, racism and other factors.”

The OHA [definition](#) of health equity is as follows:

“Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and

- Recognizing, reconciling, and rectifying historical and contemporary injustices.”

Activities that address health-related social needs are those that address an individual’s specific needs in order create conditions conducive to better health. Examples of activities that address individual health-related social needs include:

- Housing vouchers or rent assistance
- Utility bill assistance (heating, cooling, power, water)
- Job skills, interview training
- Meal services, food banks
- Health related services (recliner chair, mobility device, air conditioner, etc.)

Activities that address social determinants of health and health equity are those that affect the root causes of health or health inequity at a population level. Social determinants of health have a population health focus as opposed to an acute care or individual health focus. Examples of activities that address social determinants of health are below.

- Policy advocacy to improve a community’s social, economic, or environmental conditions, such as:
 - Minimum wage
 - Sick leave
 - Parental leave
 - Zoning, building or urban density
 - Rent control and housing affordability
 - Climate change
 - Transportation access and infrastructure
- Affordable housing support or construction
- Education advocacy
- Environmental improvements